TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

FISCAL NOTE

SJR 25

January 13, 2021

SUMMARY OF BILL: Authorizes the Governor to implement the TennCare III demonstration waiver.

ESTIMATED FISCAL IMPACT:

Other Fiscal Impact – An exact fiscal impact cannot be determined with reasonable certainty. No significant administrative cost increases are anticipated as a result of this waiver. Any increase in federal funding associated with achieved savings under this demonstration will not be known until FY22-23.

Assumptions:

- The Centers for Medicare & Medicaid Services (CMS) approved the TennCare III demonstration waiver for a period of 10 years (January 8, 2021 through December 31, 2030). CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing them would no longer be in the public interest or promote the objectives of title XIX and XXI of the Social Security Act. The state would have an opportunity for a hearing to challenge any such determination.
- Tennessee's financing structure under this demonstration uses an aggregate cap budget neutrality financing approach. Under this approach, the state will be subjected to a budget neutrality limit on the federal matching funds it receives under the expenditure authority under Section 1115(a)(2). The aggregate cap model places a fixed total dollar cap on most state expenditures for the demonstration for which federal matching funds can be obtained under the expenditure authority in Section 1115(a)(2). To the extent the state exceeds the budget neutrality limit, federal matching would be disallowed for that excess amount. Conversely, to the extent the state's expenditures turn out to be below the budget neutrality limit, the state can share in the savings achieved if it meets quality targets. Up to 55 percent of any savings achieved may be earned by the state in the form of additional federal matching funds that can be reinvested in its state health programs, limited to those programs that will support vital state health programs that address social determinants of health.
- Tennessee will continue to receive Federal matching funds for expenditures under the waiver up to the "aggregate cap" amounts for five pre-specified eligibility groups: (1) disabled individuals; (2) children; (3) adults over 65; (4) adults under 65; and (5) dual-eligibles. In the first year of the waiver, this base block grant amount will be approximately $8.6 billion. Because these caps are based on "without waiver" costs, and

because the state has historically underspent compared to these costs, Tennessee will likely see immediate shared savings under the waiver.

- The state will be given a range of operating flexibilities for this program, including the option to create a formulary of covered prescription drugs, the authority to negotiate directly with drug manufacturers, the ability to increase benefits and coverage without seeking prior approval from CMS, the power to respond to Medicaid fraud more aggressively and more.
- Under the demonstration, the state may only expand benefits and coverage under this demonstration authority; benefits and coverage cannot be reduced, as the state is required to maintain the level of benefits and coverage that are in place as of December 31, 2020. No reductions in benefits or coverage can be made by the state without an amendment and additional public comment processes. The state may only expand benefits and coverage or pilot new health programs under this demonstration authority.
- The measures being tested with this demonstration approval may have associated administrative costs, particularly at the initial stage, and CMS acknowledges that Section 1115 demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." However, CMS anticipates that the only impacts on eligibility or enrollment will be to expand eligibility and enrollment because the state has agreed to a maintenance of effort for the currently allotted funding, ensuring that there will be no changes to the current coverage and benefit levels prior to the demonstration.
- In addition, the Division of TennCare reports that all administrative expenditures will continue to receive at least a 50 percent federal match and that there are no significant administrative cost increases anticipated as a result of this waiver.
- The demonstration will also have a two-sided risk corridor mechanism that will have the state and CMS jointly share the risk of an increase or decrease by one percentage point above or below the baseline enrollment, within an eligibility group for the specific demonstration year. As long as actual enrollment is within one percentage point in either direction of the baseline enrollment value, the aggregate cap for a specific enrollment group will stay the same. If a particular eligibility group is above or below the one percentage point threshold, then an adjustment is made to the aggregate cap amount.
- Under this demonstration approval, CMS is granting the state many flexibilities requested. However, in light of the concerns expressed in the public comment period, according to CMS the state will be subject to increased oversight and monitoring to ensure that all beneficiaries have access to needed pharmaceuticals. In addition, the state must meet the standards of Essential Health Benefit plans, which align coverage with requirements of plans in the individual market insurance Marketplace, and the standards that apply under Alternate Benefit Plans under section 1937 of the Social Security Act. The formulary under the demonstration must comply with new mandatory Medication Assisted Treatment drug coverage requirements, Medicare Part D rules for mental health and other protected class drugs, and comply with other protections as outlined in the Special Terms and Conditions.
- Any proposed changes to the TennCare demonstration will continue to be subject to the existing federal notice and transparency requirements regarding 1115 demonstrations. While the demonstration provides authority for the state to make certain changes to the demonstration without prior approval by CMS, the scope of the changes are limited to what is already approvable under Medicaid authorities, and all changes must be posted

for public comment in advance with no exceptions to the transparency requirements with this authority.

- This demonstration provides the state with the authority to suspend beneficiary eligibility for up to 12 months for fraud convictions in state or local court. CMS has included several guardrails to this policy. The state will provide at least 10 days advance notice of the suspension to beneficiaries, which will include information on the nature of the suspension, as well as their right to appeal, their right to apply for Medicaid on another basis, what this status means with respect to their ability to access other health insurance coverage, and what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category.
- Due to multiple unknown factors associated with the implementation of this waiver and any future changes to the program, an exact fiscal impact cannot be reasonably determined. Any increase in federal funding will be based upon a shared savings funding mechanism and will not be known until FY22-23.

IMPACT TO COMMERCE:

Other Commerce Impact – Due to multiple unknown factors, an exact impact to commerce and jobs cannot be determined with reasonable certainty.

Assumption:

- Due to multiple unknown factors, an exact impact to commerce and jobs cannot be reasonably determined; however, it is assumed there will be an increase in health care services provided.

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.

Bojan Savic

Bojan Savic, Interim Executive Director

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